

of the cases the histories were similar to those given by Dr. Abrahamson, the onset being mild and the symptoms chiefly limited to the face and upper extremity, with slight impairment, in some instances, of the lower extremity. Through the courtesy of Dr. Janeway, the speaker said, he recently saw a case presenting this, with other features on the opposite side, at the City Hospital, in which the attack was extremely severe. The patient was comatose for a week, but the residual effects of the apoplectic seizure were very slight, being limited on the right side to a paralysis of the arm and lower face. There was no increase in the knee or ankle reflexes; no clonus; no Babinski on the right side. On the opposite side, however, there was a persistent chorea-like tremor, including the face, arm, and leg, with Babinski, clonus, and increased knee jerks, but no paralysis. The tremor was of the semi-intentional type, averaging 180 to the minute. There were marked sensory disturbances on the right side, especially to pain and to temperature. Deep sensibility was affected, but not light touch. Sensory disturbances were absent on the left side.

Dr. William Hirsch thought the main reason that cerebral monoplegia was regarded as unusual or rare was that we always had in mind that the most frequent hemorrhages occurred in the internal capsule, and were apt to overlook the fact that those forms of paralysis due to arteriosclerosis, syphilis or thrombosis were more likely to give rise to a diplegia or a monoplegia rather than a complete hemiplegia. In a case of cerebral arteriosclerosis seen comparatively recently the only manifestations were an aphonia, with very slight paralysis of the face. In another case, the only symptom was alexia. A clear distinction should be drawn between these two classes of cases; in one, complete hemiplegia was the rule, while in the other, where we had to deal with vascular changes, a complete hemiplegia was the exception, rather than the rule.

Dr. Leszynsky said he had seen a number of cases of cerebral hemorrhage in which only the face and arm were involved, but, as a rule, upon investigation one usually learned that the entire side was affected at first and that the leg recovered within a few hours or days. Such cases were not at all uncommon in his experience.

Dr. Sachs said that in the internal capsule the fibers were so close together that it was almost inconceivable that a hemorrhage there would involve the arm fibers and leave those of the leg exempt. It would perhaps become necessary at some future date to change our present views regarding the arrangement of fibers in the internal capsule.

DISCUSSION ON THE PRESENT-DAY LIMITATION OF THE CONCEPTION OF PARANOIA

By Dr. M. S. Gregory

In opening this discussion, the speaker said that he would not attempt a complete historical résumé of the paranoia problem, interesting and instructive though it might be, and would consider only those later day conceptions which were still subjects of controversy. He would make no pretense of trying to solve the paranoia problem. It was well known that the origins of paranoid delusion formation were extremely complicated, and it was not his intention to attempt a complete psychological analysis, notwithstanding its great importance, and in spite of the fact that it was

probably only through such analyses that we might ultimately come to understand some of the more subtle distinctions in this field of psychiatry.

After summing up the position assumed by Kraepelin in connection with paranoia Dr. Gregory said we were reduced to the consideration of two groups of cases: the one a comparatively large assemblage of so-called secondary paranoias or paranoid forms of dementia præcox, showing the typical intellectual deterioration, the disorder of attention and blunting of the emotional tone, with more or less systematized delusional formation; and a still narrower and numerically smaller group, in which the delusional formation was unattended by the other attributes of intellectual impairment. Under both of these groups, certain sub-divisions stood out fairly clear. After mentioning these, and illustrating them with detailed clinical cases, the speaker summarized his views as follows:

1. That the grouping of paranoia from only a symptomatic point of view was unscientific and untenable.

2. That when measured by complete clinical criteria, the paranoia group was reduced to about ten per cent. of all insanities which seemed to have some fundamental characteristics in common.

3. That this restricted group was composed of two essentially different types namely, deteriorating and non-deteriorating or degenerative, which should not be confounded.

4. That these two general groupings, owing to our present limited knowledge might, only empirically and arbitrarily, be divided into other sub-groups: (a) For clinical and therapeutic convenience. (b) To bring about an understanding among the alienists in order to avoid confusion in medico-legal questions.

(To be continued.)